Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NV5641HOS	A. BUILDING _____ B. WING _____	04/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS HOSPITAL	2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 04/16/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00024952 was substantiated with deficiencies cited. (See Tag 298). Complaint #NV00024896 could not be substantiated due to lack of sufficient evidence. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000	approach Approved 5-5-10	
S 298 SS=G	NAC 449.361 Nursing Service 9. A hospital shall ensure that its patients receive proper treatment and care provided by its nursing services in accordance with nationally recognized standards of practice and physicians' orders. This Regulation is not met as evidenced by: Based upon interview and record review, the	S 298	The patient addressed in this complaint is still a patient in the facility, he is awaiting transfer to a hospital in California at the family's request. We are awaiting an available bed for transfer. All patients have the potential to be affected by this practice. The Unit Manager has conducted an audit of the clinical staff to assess their knowledge about when it is acceptable to take a patient off of cardiac monitoring when continuous monitoring is required. In response to this,	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla Thompson — TITLE: PI Manager — (X6) DATE: 5/5/10

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S 298	Continued From page 1 facility did not ensure that one of two sampled patients received care in accordance with nationally recognized standards of practice. Specifically, a patient that was to be "continuously monitored" with a cardiac monitor, was left off his monitor for thirty-three minutes. At some point during this time period, he became unresponsive. When the nurses realized he was unresponsive, he was resuscitated. He consequently continued to be unresponsive and was assessed by the Neurologist to have a "poor" prognosis (Patient Identifier: 2). Findings: Patient 2 was admitted to the facility on 03/06/10 with diagnoses that included chest pain, end-stage renal disease with peritoneal dialysis, type II diabetes, hypertension, morbid obesity, and diabetic retinopathy. A record review was conducted of his clinical record on 04/16/10. The record indicated that he was alert and oriented upon admission. He was evaluated for chest pain, coronary artery disease and end stage renal disease, and an intra-aortic balloon pump was placed. He underwent coronary artery bypass graft surgery on 03/10/10. On 03/19/10, the record recorded that he suffered two cardiac arrests related to ventricular fibrillation, but was successfully resuscitated and placed on a ventilator. Patient 2 was still able to obey commands and was alert and oriented and able to communicate. A Nurse's Note dated 03/21/10 and entered at 5:26 AM, stated,"0400 while Pt (patient) getting bath went into asystole (witnessed) ..code called Dr. (name deleted) up from ED Code Sheet in chart..." A Nurse's Note dated 03/21/10 at 8:00 AM noted "Pt. (patient) is unresponsive, with left	S 298	a thorough investigation of the two clinical staff involved in this patient's care at the time of his cardiac event was completed. One nurse's employment was terminated and the second was placed on a corrective action plan. Based on the results of the investigation, a report was filed with the Nevada Board of Nursing. All clinical staff are required to review the standards of care for critical care patients. A review of patient specific alarm settings occurs with the hand off communication. This information has also been conveyed to staff via the shift huddles conducted prior to the start of each shift. Compliance with these standards will be monitored through tracers completed by Unit Manager or designee. Individual Responsible: Unit Manager, Director, Clinical Supervisors Completed: 4/30/10	

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S 298	Continued From page 2 pupil 4mm (millimeters) non-reactive to light. No gag or gough (sic) reflex with ET (endotracheal) suctioning although pt. slightly opened left eye...". On 03/22/10 at 6:30 PM, nursing staff documented that "Dr. (name deleted) was here family asked questions & he directly told family that his condition is very very poor. In am. (sic) EEG (electroencephlogram) will be done to check his brain waves...". Patient 2 was evaluated by the physician on 03/23/10. The record indicated that a neurologic exam found Patient 2 to be "unresponsive. On painful stimuli, he does open his eyes. He does not follow any commands. On sternal rub, there is some decerbrate-type posturing noted. Planters are bilaterally extensor. I could not elicit any reflexes...". The record contained another consultation dated 03/24/10 entitled, "Second opinion regarding altered mental status after hypoxic event". That physician noted that Patient 2 "had a significant hypoxic event and has evidence of very little cortical and brainstem function. His EEG, however, does show some cortical rhythms. There is very little chance that there will be meaningful recovery for this patient". On 04/16/10, Staff 4, the Critical Care Manager, a Registered Nurse was interviewed. She stated that on 03/21/10, Patient 2 was in a unit that required all patients to be "continuously monitored" by a cardiac monitor. She stated that this requirement was a "standard of practice". Cardiac monitoring consisted of "leads" that are attached to a patient's chest. She stated that during a bath on that date, two nurses had removed the leads from 3:21 AM through 3:54 AM. At some point during that time Patient 2 stopped participating in the bath and following commands. When the nurses realized he was	S 298		

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S 298	Continued From page 3	S 298		

unresponsive, they called a "code" during which Patient 2 was identified as being in "asystole" (flatline electrocardiogram). She indicated that it was inappropriate for a patient that was to be continuously monitored to be off the monitor for that long. She stated that after the incident, and she conducted an audit of nursing staff to determine their knowledge of when to it was acceptable to take a patient off the cardiac monitor when continuous monitoring is required. She further stated that two nurses were bathing Patient 2 and that as a result of her investigation, one of the nurses is no longer employed at the facility.

On 04/15/10, Patient 2 underwent a tracheostomy. The "indications" given by the physician was that Patient 2 "was on the floor (unit) and sustained unwitnessed cardiac arrest from which he has suffered what appears to be irreversible neurologic hypoxic brain damage".

On 04/20/10, Staff 3, a Registered Nurse, Performance Improvement contact for the facility, was interviewed telephonically. She provided the document included in the orientation manual given to both critical care nurses involved in the bathing incident, entitled "Standards of Basic Nursing Care". The document stated, "Nursing care in the Critical Care units at (name of facility) is based upon standards established by the American Association of Critical Care Nurses...Continuous cardiac monitoring is done on all patients".

Based upon the findings of this investigation the allegation was substantiated.
Surveyor: 28849.